



ADA Compliance Program

COMPLAINT FORM

Complainant Information

Complainant's Name:		
Address:		
City:	State:	Zip Code:
Day Phone:		Evening Phone:

Person Alleged to Have Been Discriminated Against

Name:		
Address:		
City:	State:	Zip Code:
Day Phone:		Evening Phone:

Basis of Complaint

<input type="checkbox"/> Employment	<input type="checkbox"/> Structural Accessibility	<input type="checkbox"/> Parking	<input type="checkbox"/> Other
<input type="checkbox"/> County Programs, Services & Activities		<input type="checkbox"/> Section 504-Federally Funded Programs	

Date the incident took place:

Witnesses:

1. Name:		
Address:		
City:	State:	Zip Code:
Day Phone:		Evening Phone:
2. Name:		
Address:		
City:	State:	Zip Code:

Day Phone:	Evening Phone:
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Name and location of institution, or agency that you believe discriminated against you?

Name of institution or agency:		
Address:		
City:	State:	Zip Code:
Day Phone:	Evening Phone:	
Name of institution/agency representative to contact:		

Please describe the reason you believe discrimination took place.

Resolution

Have you tried to resolve the complaint through informal procedures at the institution or agency? ☐ Yes ☐ No

If “yes”, what was the result and/or what is the status of the complaint?

Complainant's Signature

Name:

Date:

You may attach any written material, photographs or other documentation that you feel is relevant to the complaint.

For Internal Use Only

Receipt of Complaint (Date):

Received by: